



AGENCY OF HUMAN SERVICES
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
103 South Main Street
Waterbury, VT 05671-2306
<http://www.dail.vermont.gov>
Voice/TTY (802) 871-3317
To Report Adult Abuse: (800) 564-1612
Fax (802) 871-3318

December 22, 2014

Mr. Christopher Keough, Administrator
St Joseph's Residential Care Home
243 North Prospect Street
Burlington, VT 05401-1609

Dear Mr. Keough:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **November 13, 2014**. Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

A handwritten signature in cursive script, appearing to read "Pamela M. Cota".

Pamela M. Cota, RN
Licensing Chief



Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0155	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 11/13/2014
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

ST JOSEPH'S RESIDENTIAL CARE HOME

243 NORTH PROSPECT STREET
BURLINGTON, VT 05401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R100	Initial Comments: An unannounced on-site complaint investigation was conducted on 11/13/14 by the Division of Licensing and Protection. The following regulatory violation was identified:	R100	St. Joseph's Residential Care Home has completed comprehensive plans of care for each resident based on abilities and needs identified in the resident assessment.	12/8/14
R145 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.9.c (2) Oversee development of a written plan of care for each resident that is based on abilities and needs as identified in the resident assessment. A plan of care must describe the care and services necessary to assist the resident to maintain independence and well-being; This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the home failed to assure the care plans reflected the current status and needs of 2 of 4 residents reviewed. (Residents #1 and #4). Findings include: 1. Per record review Resident #1, admitted on 2/22/12 with Dementia, had an annual Resident Assessment, dated 2/28/14, that identified the resident as having moderate cognitive impairment. The resident was also identified as having been physically and verbally abusive on occasion. Progress notes during the month of November and December of 2013, revealed the resident had wandered into other resident rooms and had been verbally aggressive towards other residents. A progress note, dated 1/26/14, indicated that Resident #1 had put his/her hands around the neck of Resident #2 and choked that resident. Subsequent notes revealed the	R145	St. Joseph's Home will maintain nursing audits of all resident care plans to include: <ul style="list-style-type: none"> . Physician comprehensive and complete medical and diagnosis list. . Physician orders and collaborative health service providers. . Medication administration record/treatment record. . Nursing notations and monthly summaries. . Nursing assessments. Resident #1 care plan updated to include: <ul style="list-style-type: none"> . Staff training regarding interventions with resident during times that the resident is agitated. . Guiding the resident away from the source of distress. . Diverting the resident's attention to sources of strength, ie music and singing and travels abroad 	12/8/14

Division of Licensing and Protection

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

DATE FORM

Christine M. Neufeld, Administrator

12-15-14

6899

5G8V11

If continuation sheet 1 of 3

R145 POC accepted 12/18/14 B. HANSEN/PMC

Division of Licensing and Protection

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R145	Continued From page 1 following: on 5/4/14 Resident #1 was involved in a verbal confrontation with other residents, becoming increasingly aggressive toward them, which reportedly frightened other residents who verbalized fear that Resident #1 might punch one of them; on 5/18/14 Resident #1 reportedly pushed another resident and made him/her cry; on 6/24/14 the resident pushed Resident #5, upsetting him/her and on 7/4/14 Resident #1 became angry with, and hit Resident #3 on the arm. Despite these incidents, the care plan, which had not been updated since 2/3/14 did not address the ongoing aggressive behaviors revealed in May, June and July of 2014. In addition, although the care plan states to 'monitor frequently' it does not define what that means. 2. Per record review Resident #4, admitted on 8/29/12 had a family meeting on 3/14/14 to discuss the resident's increasing behaviors, the inability of the home to continue to meet the resident's needs and the need for higher level of care. A plan was put into place, while attempting to find appropriate placement, to add a private or personal care giver to work with Resident #4 (3) times per week. A Resident Assessment was conducted on 10/3/14, as the result of a significant change in status, that indicated Resident #4 had a moderate cognitive impairment and exhibited behaviors that included; socially inappropriate, verbally and physically abusive on occasion and a risk of wandering outside - leaves and gets lost. A progress note, dated 10/23/14, stated that at 2:00 AM the resident, who used a rolling walker for ambulating, was "found on stairs w/out [his/her] walker...was down one flight of stairs...looking for [his/her] car...Very confused Assisted back to room via walker..." Although the resident's care plan, dated June 2013, had been updated on	R145	.Continual monitoring particularly during evening hours in living room areas. .Educating residents to walk away from confrontation and seek assistance from a staff member. . Activities Director will provide resident 1 with tasks during the day to occupy her with meaningful contributions to the Home. (See Attached) A care plan meeting was held for resident #4 on 10/29/14. In attendance was St. Joseph's Director of Nursing and three of the resident's children. Issues discussed were as follows: .Toileting - The resident seems unaware of bowel movements, and is not able to clean himself. .The resident continues to have altered memory and periods of lucidity wherein he is oriented to person and place. .The resident has been attempting to exit the building via the stairwell near his room. Summary of Care Plan Meeting The three adult children	12/8/14

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R145	Continued From page 2 10/14/13 to reflect "increasing incidences of aggressive or threatening behaviors" it had not been revised to reflect the increase in wandering behaviors and the need for heightened supervision and monitoring of the resident. The covering RN and LPN both confirmed, during interview on the afternoon of 11/13/14, that the care plans for Residents #1 and #3 did not reflect either resident's current status or needs.	R145	who were present at the meeting agreed that their father requires a higher level of care. This was discussed with resident #4 in his room, and he verbally agreed with a plan to move him to a higher level of care facility. Resident #4 care plan updated to include: .A large red stop sign has been placed on the door outside the resident's room as a visual deterrent from using the stairs. .St. Joseph's nursing staff will continue to provide the resident with ERC level of care. .The Activities Director will continue to encourage resident's participation in Home activities. .St. Joseph's Home has assisted family members with finding a suitable, secure Level II facility. Resident #4 is currently on a waiting list for one facility, and will remain at St. Joseph's until a room opens at the facility (See Attached)	